STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 15,916
	)	
Appeal of	)	
	)	

INTRODUCTION

The petitioner appeals a decision by the Department of Social Welfare denying payment for certain medical expenses under the Vermont Health Access Program (VHAP). The issue is whether the petitioner was covered under the program at the time in issue.

FINDINGS OF FACT

1. The petitioner, who is a twenty-two-year old single woman who was formerly employed as a waitress but who is currently unemployed, began receiving VHAP benefits in August of 1996. In November of 1997, the petitioner moved from the western side of the state to the eastern side and, at some point near the time of her move, gave the Department her new address.

2. Records submitted by the Department show that the petitioner was mailed a notice dated December 5, 1997, informing her that her VHAP eligibility was being reviewed and asking her to complete and return enclosed forms, to make an appointment for an interview, and to provide verification of her income. She was told in the notice that she had to provide this information before January 1, 1998 in order to continue her benefits. She was advised that if

she did not respond to this request by the above date that her benefits would end on January 31, 1998. This notice was mailed by the western office (which had originally served her) to the petitioner's old address and was not returned to the Department as undeliverable. The petitioner says that her mail was forwarded to her by the post office for a considerable period of time after she moved. She says it is possible that she got this letter but does not recall receiving it.

3. When the petitioner did not respond to this notice, the eastern office of the Department (which was to take over her case) sent a second notice dated January 20, 1998 to the petitioner at her new address informing her that her eligibility would end on January 31, 1998, due to her failure to respond to the request for information and advising her that she could reapply at any time. The petitioner does not recall receiving this notice either. The Department has no record of the notice being returned as undeliverable.

4. In the subsequent months, the petitioner incurred medical and dental bills which she thought were covered by VHAP. In fact, the managed care provider for VHAP did continue to pay her bills after February 1, 1998, because of a lag time between the Department's termination decision and notice of that fact to the managed care payor.

5. Although the petitioner had a vague recollection

of visiting the eastern office in the next few months, though the Department's records show no evidence of any contact from the petitioner until she came in to apply for Food Stamps in June of 1998. That was the first time her current worker met the petitioner. During that interview in June of 1998, the worker went over the status of all of the petitioner's benefits, including her VHAP closure on February 1, 1998. The petitioner seemed genuinely surprised to learn that she had not been covered by VHAP benefits for the last four or five months. At the worker's suggestion, she reapplied for benefits on June 30, 1998 and her VHAP was reinstated on July 7, 1998. The petitioner asked for retroactive VHAP benefits covering the prior months when she had been cut off so that all her bills would be paid. The worker told her that no retroactive benefits were available in the VHAP program and the petitioner appealed that decision. The petitioner did not mention to the worker at that time that her bills were still being paid by the managed care provider.

6. The petitioner had her case set for hearing by the Board and reset three times but her appeal was ultimately dismissed by the Board on January 14, 1999, for failure to show up for her hearing. See Fair Hearing No. 15,571. Two months later, in March of 1999, the petitioner received some new bills from her medical and dental providers showing that the amount originally paid by CHP (about $550) for the

period from February 1 through July 7, 1998 had been reversed and reclaimed due to her lack of eligibility during that period. The petitioner appealed that decision on July 17, 1998, claiming that she should have been found eligible for VHAP during that period of time.

ORDER

The petitioner's appeal is dismissed as concerning issues which are res judicata, or already decided by the Board.

REASONS

The issue raised by the petitioner in this appeal is exactly the same as the one raised by her in her July, 1998, appeal--whether she should have been eligible for VHAP benefits and payment of her Medicaid and dental bills from February 1 through July 7, 1998. That appeal was decided against the petitioner because she failed to attend her hearing. When an appeal is decided by default it is still a final decision by the Board on the underlying issue which was raised. The Board dismissed the petitioner's appeal which resulted in an affirmance of the Department's position that she should not have been eligible for that period of time. As such, the issue is res judicata or "a thing which is already decided" and cannot be relitigated absent a showing of some extenuating circumstance, such as newly

discovered evidence or fraud.

Even if this were not so, the Board's fair hearing rules require that a decision be appealed within 90 days of the date a grievance arises. Fair Hearing Rule No. 1. The petitioner certainly knew by the end of June 1998, that the Department had determined her to be ineligible for February 1 through July 7, 1998 and that she had a right to appeal that decision. Her grievance with regard to her eligibility began at that time and any appeal of that determination had to be made by the end of September of 1998.

The petitioner apparently understood that she had a grievance when she lodged her first appeal. The petitioner may have believed that she had a new ground for appeal when she found out the payments were reversed in March of 1999, but that reversal was only the consequence of the prior ruling that she was ineligible for benefits.[1] It is certainly an outcome which the petitioner should have expected to flow from a finding of ineligibility for those benefits and, if there was any uncertainty on her part about what would occur, she could have and should have discussed it with her worker (who was unaware that the benefits were still being paid out by the managed care provider). The consequence does not form a new ground for appealing the

[1] Of course, the petitioner could appeal an error in the amount of the consequence, such as an improperly reversed amount. The basis of her appeal here, though, is that the consequence should not be imposed because she should not have been found ineligible for benefits.

underlying ineligibility and the current appeal should be dismissed as having been previously decided.

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